PUBLIC HEALTH SERVICES DISTRICT
COCONINO COUNTY

CHILD CONSENT FOR VACCINATION
SEASONAL FLU 2014-2015

□ App
□ Walk-in
Time

Last Name *(of person receiving vaccination)*:			First Name:	MI:	
Mailing Address:			City	State	Zip Code
Date of Birth:	Age:	□Male □Female	Phone Number:	Mother's Maiden Name	

Race: (*select one; for statistical purposes only):* □ Not Hispanic/ Latino □ Hispanic/Latino

Ethnicity*: (For statistical purposes only. If necessary, you may choose more than one)*
□ White □ Hispanic/Latino □ American Indian/Native Alaskan □ Black/ African American □ Asian
□ Hawaiian/ Pacific Islander □ Other →(describe): _____

Please check the box that applies:

❑ Health Insurance – Fill out portion below

Name of Insurance: _____ Is this an AHCCCS Plan? Yes or No

Subscriber Name:_____SS#_____DOB_____

ID#_____Group#_____Relationship to Subscriber_____

****Note:** If your plan does not cover influenza vaccine, you will be billed as the responsible party for $15 per child.*

❑ Underinsured: insurance that does not pay for Flu vaccine - *high deductible plans are **not** considered underinsured*

❑ Native American and/or Alaskan Native

❑ **Have no health insurance**

_____I have read or have had explained to me the information contained in the Vaccine Information Statements (VIS) for 2014-2015 about the seasonal influenza vaccine. **My child is not sick today, does not have a *serious* allergy to eggs, and has not had any previous bad reaction to the influenza vaccine.** I have had a chance to ask questions that were answered to my satisfaction. I agree to have Coconino County release my information about this vaccination to the Arizona State Immunization Information System (ASIIS) and other healthcare providers, if requested. I understand the benefits and risks of the influenza vaccine and want my child to receive the vaccine I requested today. If you are billing my insurance, I hereby authorize CCPHSD to furnish information to insurance carriers concerning my visit, and I assign payments for medical services rendered to CCPHSD. I understand that I am financially responsible for all charges whether or not covered by insurance.

******Please fill out reverse side if you would like your child to be screened for Intranasal Flu mist******

Signature of patient or guardian	Print Name	Date

FOR STAFF USE ONLY

Clinic Location: _____ **Admin Initials***:* _____

PAYMENT DETAILS: *Client may request copy for records. Please ensure all areas are completed for billing purposes.*

☐ Fee Waived ☐ Client Responsible ☐ Bill Insurance ☐ Bill Company _____

Fee/Donation $_____ Form of payment: **Cash** **Check** **CC** Receipt # _____

Vaccine Selection

Initials	Age Group	Manufacturer	Lot #	VFC/Pay	Site	Route	Dose
	6mos- 35 mos	**Sanofi** prefilled syringe			□LVL □ RVL □ LD □ RD	IM	**0.25ml**
	3 yrs– 18 yrs	**Sanofi** SDV			□ LD □ RD	IM	0.5ml
	2 yrs-18yrs	**MedImmune** Nasal Mist			R and L nares	Intranasal	0.1ml per nare
	3 yrs– 18 yrs	**Sanofi** MDV			□ LD/ □ RD	IM	0.5ml
	6mos- - 35mos	**Sanofi** MDV if no Syringes			□LVL□ RVL □ LD □ RD	IM	**0.25ml**

Please provide reminder slips to children under 9 years if 2nd dose necessary this year

_____

Nurse's Signature **Date**